TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Pain Relief Group

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-16-0354-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $5,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Pursuant to Commission Rule 133.307(d) Texas Mutual files the attached, completed response, and related items."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 14, 2014 December 31, 2014 December 31, 2014 August 6, 2015 November 12, 2014 November 12, 2014 January 23, 2015	99214 G0431 99214 99214 G0431 99214 99214	$5,000,00	$672.76

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out requirements for medical bill submission by health care providers.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing errors
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 225 – The submitted documentation does not support the service being billed
   - 758 – ODG Documentation requirements for urine drug testing have not been met (Not maintained as carrier elected to pay)
   - W3 – In accordance with TDI-DWC Rule 134.803, this bill has been identified as a request for reconsideration
   - 150 – Payer deems the information submitted does not support this level of service
   - 193 – Original payment decision is being maintained
   - 29 – the time limit for filing has expired
   - 731 – Per 133.20(B) provider shall not submit a medical bill alter than the 95th day after the date the service
   - 891 – No additional payment after reconsideration
   - 876 – Required documentation missing or illegible
   - 890 – Denied per AMA CPT code description for level of service and/or nature of presenting problems
   - 928 – HCP must submit documentation to support exception to timely filing of bill.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Was the date of service in dispute submitted timely?
3. What is the applicable rule pertaining to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The services in dispute are related to professional medical services. The insurance carrier denied disputed services with several claim adjustment reason code found below;

   - 99214 – Date of service October 14, 2014, December 31, 2014, August 6, 2015, and November 12, 2014 as 225 – "The submitted documentation does not support the serviced being billed" and 150 – "Payer deems the information submitted does not support this level of service."

   The submitted code is described as 99214 – "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family."

   Review of the submitted documentation finds;

   Date of service October 14, 2014 – Submitted documentation supports: Complete Review of systems, Complete (past medical, family, social history), and Comprehensive Exam. The Division finds 2 of the 3 key components (A detailed history; A detailed examination) were met by the submitted "Progress Note". The carrier's denial is not supported for this date of service.

   Date of service December 31, 2014 – Submitted documentation supports: Complete Review of systems, Complete (past medical, family, social history), and Comprehensive Exam. The Division finds 2 of the 3 key components (A detailed history; A detailed examination) were met by the submitted "Progress Note". The carrier's denial is not supported for this date of service.

   Date of service August 6, 2015 – Submitted documentation supports: Complete Review of systems, Complete (past medical, family, social history), and Comprehensive Exam. The Division finds 2 of the 3

key components (A detailed history; A detailed examination) were met by the submitted "Progress Note". The carrier's denial is not supported for this date of service.

28 Texas Administrative Code §134.203 (b) requires that "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;." The insurance carrier's denial reason for the services the above services in dispute is not supported. These disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. The date of service January 23, 2015 for code 99214 was denied as 29 – "The time limit for filing has expired". Review of the submitted documentation finds a copy of the medical bill for this date of service with the signature date May 8, 2015. 28 Texas Administrative Code 133.20 (b) states, "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill." Insufficient evidence was found to support this claim was submitted prior to the 95th day. The carrier's denial is supported for this date of service. No additional payment can be recommended.

3. 28 Texas Administrative Code 134.203 (c) states, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor)." 28 Texas Administrative Code 134.203 (e) states, "The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and, (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service."

   CMS payment policy files identify those clinical laboratory codes which contain a professional component, and those which are considered technical only. The codes in dispute are not identified by CMS as having a possible professional component, for that reason, the MAR is determined solely pursuant to 28 TAC §134.203(e)(1). The maximum allowable reimbursement(MAR) for the services in dispute is 125% of the fee listed for the codes in the 2015 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at http://www.cms.gov.

   The Maximum Allowable Reimbursement for the services in dispute is calculated as follows:

Date of Service	Submitted Code	Charge	MAR 134.203 (c) or (e)	Carrier Paid	Amount due
October 14, 2014	99214	$600.00	(DWC Conversion Factor / Medicare Conversion Factor) x Participating Amount or (55.75 / 35.8228) x $102.92 = $160.17	$0.00	$160.17
December 31, 2014	G0431	$1,000.00	Medicare fee x 125% or $75.82 x 125% = $94.78	$0.00	$94.78
December 31, 2014	99214	$600.00	(55.75 / 35.8228) x $102.92 = $160.17	$0.00	$160.17
August 6, 2015	99214	$600.00	(56.2 / 35.9335) x $104.13 = $162.86	$0.00	$162.86
November 12, 2014	G0431	$1,000.00	$75.82 x 125% = $94.78	$0.00	$94.78
November 12, 2014	99214	$600.00	(55.75 / 35.8228) x $102.92 = $160.17	$160.17 pd June 29, 2015	$0.00
				Total	$672.76

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $672.76.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $672.76 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		November , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.